

Evaluation & Management Services Guidelines

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This week we are unveiling new, draft documentation guidelines for evaluation and management (E&M) services. After pilot testing, these simplified guidelines will replace the current ones. These guidelines are important because a properly documented medical record is essential to good clinical care. It eases communication and coordination among physicians and other health care professionals. Proper documentation also ensures that taxpayer dollars are spent in accordance with the law and that the level of service in a submitted claim was, in fact, the level provided.

Unfortunately, too much care is not being properly documented. The congressionally mandated audit of fiscal year 1999 Medicare claims by the Department of Health and Human Services Inspector General (IG) attributed \$5.5 billion in improper payments to inadequate or nonexistent documentation.

For example, one physician billed for nine hospital visits but documented only three. Another physician billed for a level III office visit and a cardiovascular stress test, but the record did not demonstrate that any history taking, physical examination, or medical decision making actually took place to justify a separate E&M service.

It is not unusual for well-intentioned physicians to code as much as two levels apart for identical services because of varying interpretations of definitions of histories, physicals, and medical decision making in the *CPT-4* coding system used for filing claims. The IG audit showed that coding for level IV office visits and level III hospital visits are especially problematic.

Working closely with the American Medical Association (AMA), we first developed E&M documentation guidelines in 1995. In 1997, again in close conjunction with the AMA, we updated them and, at the request of various specialty societies, added more detail to try to recognize specialists' more narrowly focused clinical encounters. The result, however, was cumbersome and troubling to many physicians, given documentation's importance in separating honest errors from the far fewer instances of fraud and abuse.

The IG's findings confirm what we and many physicians already knew we need better, simpler, clearer documentation guidelines. That is why physicians at HCFA, including Center for Health Plans and Providers Director Robert Berenson, MD, Paul Rudolf, MD, Laurie Feinberg, MD, and Barbara Paul, MD, have gone back to the 1995 version, which was more agreeable to the medical community, to start over with three goals in mind: simplify the guidelines; reduce the burden; and foster consistent and fair medical review.

In the new guidelines, we are simplifying the physical examination to three levels based on the number of organ systems examined. For example, a detailed examination includes findings from three to eight organ systems, rather than the total number of items examined. The requirements for review of systems are also based on organ systems. Counting of elements in an examination is virtually eliminated, as are incentives to perform unnecessary examinations.

We simplified medical decision making to three levels as well, with clear requirements that will be cross-referenced to specialty-specific vignettes to aid reviewers in making accurate determinations. These vignettes will capture the nuances of each medical specialty and prevent arbitrary application of and dependence upon generic, inflexible, and often meaningless lists of elements.

We believe our new, simpler guidelines will provide clear and unambiguous guidance and streamline the documentation required for clinically appropriate record keeping and verification that services were medically necessary and rendered as billed. However, we want to know for sure that they will work in the real world of clinical practice. Therefore, we are going to rigorously test the simplified guidelines.

Our pilot tests will focus on the basic revision of the original 1995 guidelines that is designed to minimize counting of elements and that uses a series of physical examination and medical decision-making scenarios to help physicians and reviewers assign a level of service.

We will test a second version that focuses more on how physicians make medical decisions and less on history and physical examination. It involves little or no counting and includes medical decision-making scenarios.

Comprehensive and continuing education on use of any new guidelines is critical for making sure physicians can use them efficiently and effectively. We will therefore also test training mechanisms and maintain an ongoing array of the most effective training options when new guidelines are in place.

We hope to begin the pilot testing this year, with results available as early as next summer and new guidelines in place in 2002. Throughout the process, we will seek physician advice. Most important, we want physicians to tell us whether the revisions being tested are, in fact, better for them in the real world of day-to-day clinical practice.

If test results demonstrate that further work is needed, we will make additional adjustments. We must know before proceeding whether we have indeed found a simpler, clinically meaningful, and nonintrusive approach to documentation that we all can live with.

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